COVID Vaccine Screening Form

Name: _____ DOB: _____

Address: _____ City: _____

Zip: _____ County: _____

Phone: _____ Email:_____

How do you prefer to be contacted: □ Email □ SMS □ Both □ None

Gender: □ Male □ Female

Race: □ White □ Black or African American □ American Indian or Alaska Native □ Asian

□ Native Hawaiian or Pacific Islander □ Mixed _____ □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Are you an Essential Frontline Worker (Police, EMS, Firefighter): □ Yes □ No

What is the name of your employer: _____

Do you reside or work in a long-term care/assisted living facility? □ Yes □ No

Name of facility: _____

Are you a member of a state or federal recognized tribal nation? □ Yes □ No

If yes, what is the name of your community? _____

How many conditions known to increase risk of severe illness from COVID-19 do you have?

(Cancer, chronic kidney disease, COPD, heart conditions, weakened immune system, obesity/severe obesity, Smoking, diabetes)

□ None

□ 1

□ 2 or more

Precautions	**YES**	**NO**
1. Do you have a fever or feel sick today?	□	□
2. Do you have any food or medication allergies? If yes, explain _____	□	□
3. Have you ever had a serious reaction to a previous vaccine or an injectable medication?	□	□
4. Did you have a serious reaction to the first COVID vaccine? N/A □	□	□
5. Have you received any vaccine in the last 14 days?	□	□
6. Have you tested positive for COVID-19 in the last 30 days?	□	□
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 30 days?	□	□
8. Are you pregnant or breastfeeding?	□	□

Consent:

□ I have been given a copy and read the Emergency Use Authorization containing information on the COVID vaccine including possible side effects.

□ I will not hold Blue Ridge Health/Henderson County Health Department responsible for any complications arising from my decision to have this vaccination.

□ I consent to receive the COVID vaccine today.

□ I agree to wait near the vaccination area at least 15 minutes to receive treatment in case of an adverse reaction.

□ I consent to have this documentation placed in my employee chart.

□ I understand this vaccine consist of two doses, and I must receive the second vaccine dose 28 days following the first vaccine dose.

Signature: _____ Date: _____

ADMINISTRATION:

Vaccine Administration Date: _____ Lot Number: _____

Nurse administering vaccine: _____ Site: _____

Dose 1of 2 _____ Dose 2 of 2 _____

□ Entered in CVMS